

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09430

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Dorchester Co.</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md. Rural</u> c. LENGTH OF STAY IN 1b <u>1 Hour</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rural Electrification</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Richmond Va.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Richmond, Va.</u> <u>83X-3</u> d. STREET ADDRESS <u>Richmond, Va.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Stewart</u> Middle <u>Ryland</u> Last <u>Ament Jr.</u>		<b>4. DATE OF DEATH</b> Month <u>Sept.</u> Day <u>6</u> Year <u>19 57</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>April 25, 1935</u>
<b>9. AGE</b> (In years last birthday) <u>22</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Electrical Cont.</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Richmond Va.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>-Stee- Stewart R. Ament Sr.</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Lucille Carter</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b> <u>223-40-2518</u>	
<b>17. INFORMANT</b> <u>Mrs. Stewart Ament Jr.</u>		<b>Address</b> <u>Cambridge Hotel</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <u>Electrocution</u>  <u>914.8</u>            DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.           <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>(b)</b>  <b>DUE TO</b> </div> <div style="width: 45%;"> <b>(c)</b> </div> </div> </div> <div style="width: 15%; text-align: center;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <u>instant</u> </div> </div>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Came in contact with 7200 volt wire.</u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>8:30 AM. 9/6/57</u>		<b>20d. INJURY OCCURRED</b> While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>in field</u>	
<b>20f. (City or town)</b> <u>Cambridge, RFD. Dor. Md.</u>		<b>(County)</b> <u>Richmond</u> <b>(State)</b> <u>Virginia.</u>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
<b>ACTUAL SIGNATURE</b> <u>John Mace Jr.</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>EXAMINER'S NAME (Type)</b> <u>Dr. John Mace Jr.</u>		<b>DATE SIGNED</b> <u>9/7/57</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>Sept. 9, 1957</u>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Riverview Cemetery</u>		<b>22d. LOCATION (City, town, or county)</b> <u>Richmond</u> <b>(State)</b> <u>Virginia.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>LeCompte Funeral Service</u>		<b>ADDRESS</b> <u>Cambridge Md.</u>	
<b>24a. REC'D BY REGISTRAR</b> <u>John Mace Jr.</u>		<b>24b. REGISTRAR'S SIGNATURE</b>	
<b>DATE</b> <u>9/7/57</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

SEP 9 1957

BUREAU V. S.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS. 02111  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF MEDICAL EXAMINER: [illegible]  
DATE: [illegible]

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE MEDICAL EXAMINER, BOSTON, MASS. 02111.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09431

9440

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>1 Mo 3 das</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown 17x2.2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS <u>U</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frank P Anthony</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-29-1882</u>	9. AGE (In years lost birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u> Hours <u>15</u> Min.	IF UNDER 24 HRS. Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WATERMAN</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRANK B ANTHONY</u>				14. MOTHER'S MAIDEN NAME <u>SARAH DIXON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-32-7215</u>		17. INFORMANT Address <u>Hospital Records Cambridge</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-Pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 Month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. ft. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>JULY 30, 1957</u> , to <u>SEPT 2, 1957</u> , that I last saw the deceased alive on <u>SEPT 1, 1957</u> , and that death occurred at <u>7:25 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas J Dredge</u> M.D.				ADDRESS (Street, city or town, state) <u>Cambridge Md</u> DATE SIGNED <u>Sept 2 '57</u>			
PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 4, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Catholic Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Queenstown Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Barton Bros. by John H Barton Jr. Centerville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>9/5/57</u>		24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>	

# CERTIFICATE OF DEATH

Form 100-10

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. RACE [Faint text]		4. DATE OF BIRTH [Faint text]		5. PLACE OF BIRTH [Faint text]	
6. DATE OF DEATH [Faint text]		7. PLACE OF DEATH [Faint text]		8. CAUSE OF DEATH [Faint text]		9. MANNER OF DEATH [Faint text]		10. SIGNATURE OF DECEASED [Faint text]	
11. SIGNATURE OF WITNESS [Faint text]		12. SIGNATURE OF PHYSICIAN [Faint text]		13. SIGNATURE OF MINISTER OF RELIGION [Faint text]		14. SIGNATURE OF CORONER [Faint text]		15. SIGNATURE OF JURY [Faint text]	
16. SIGNATURE OF DECEASED [Faint text]		17. SIGNATURE OF WITNESS [Faint text]		18. SIGNATURE OF PHYSICIAN [Faint text]		19. SIGNATURE OF MINISTER OF RELIGION [Faint text]		20. SIGNATURE OF CORONER [Faint text]	
21. SIGNATURE OF JURY [Faint text]		22. SIGNATURE OF DECEASED [Faint text]		23. SIGNATURE OF WITNESS [Faint text]		24. SIGNATURE OF PHYSICIAN [Faint text]		25. SIGNATURE OF MINISTER OF RELIGION [Faint text]	
26. SIGNATURE OF CORONER [Faint text]		27. SIGNATURE OF JURY [Faint text]		28. SIGNATURE OF DECEASED [Faint text]		29. SIGNATURE OF WITNESS [Faint text]		30. SIGNATURE OF PHYSICIAN [Faint text]	
31. SIGNATURE OF MINISTER OF RELIGION [Faint text]		32. SIGNATURE OF CORONER [Faint text]		33. SIGNATURE OF JURY [Faint text]		34. SIGNATURE OF DECEASED [Faint text]		35. SIGNATURE OF WITNESS [Faint text]	
36. SIGNATURE OF PHYSICIAN [Faint text]		37. SIGNATURE OF MINISTER OF RELIGION [Faint text]		38. SIGNATURE OF CORONER [Faint text]		39. SIGNATURE OF JURY [Faint text]		40. SIGNATURE OF DECEASED [Faint text]	
41. SIGNATURE OF WITNESS [Faint text]		42. SIGNATURE OF PHYSICIAN [Faint text]		43. SIGNATURE OF MINISTER OF RELIGION [Faint text]		44. SIGNATURE OF CORONER [Faint text]		45. SIGNATURE OF JURY [Faint text]	
46. SIGNATURE OF DECEASED [Faint text]		47. SIGNATURE OF WITNESS [Faint text]		48. SIGNATURE OF PHYSICIAN [Faint text]		49. SIGNATURE OF MINISTER OF RELIGION [Faint text]		50. SIGNATURE OF CORONER [Faint text]	
51. SIGNATURE OF JURY [Faint text]		52. SIGNATURE OF DECEASED [Faint text]		53. SIGNATURE OF WITNESS [Faint text]		54. SIGNATURE OF PHYSICIAN [Faint text]		55. SIGNATURE OF MINISTER OF RELIGION [Faint text]	
56. SIGNATURE OF CORONER [Faint text]		57. SIGNATURE OF JURY [Faint text]		58. SIGNATURE OF DECEASED [Faint text]		59. SIGNATURE OF WITNESS [Faint text]		60. SIGNATURE OF PHYSICIAN [Faint text]	
61. SIGNATURE OF MINISTER OF RELIGION [Faint text]		62. SIGNATURE OF CORONER [Faint text]		63. SIGNATURE OF JURY [Faint text]		64. SIGNATURE OF DECEASED [Faint text]		65. SIGNATURE OF WITNESS [Faint text]	
66. SIGNATURE OF PHYSICIAN [Faint text]		67. SIGNATURE OF MINISTER OF RELIGION [Faint text]		68. SIGNATURE OF CORONER [Faint text]		69. SIGNATURE OF JURY [Faint text]		70. SIGNATURE OF DECEASED [Faint text]	
71. SIGNATURE OF WITNESS [Faint text]		72. SIGNATURE OF PHYSICIAN [Faint text]		73. SIGNATURE OF MINISTER OF RELIGION [Faint text]		74. SIGNATURE OF CORONER [Faint text]		75. SIGNATURE OF JURY [Faint text]	
76. SIGNATURE OF DECEASED [Faint text]		77. SIGNATURE OF WITNESS [Faint text]		78. SIGNATURE OF PHYSICIAN [Faint text]		79. SIGNATURE OF MINISTER OF RELIGION [Faint text]		80. SIGNATURE OF CORONER [Faint text]	
81. SIGNATURE OF JURY [Faint text]		82. SIGNATURE OF DECEASED [Faint text]		83. SIGNATURE OF WITNESS [Faint text]		84. SIGNATURE OF PHYSICIAN [Faint text]		85. SIGNATURE OF MINISTER OF RELIGION [Faint text]	
86. SIGNATURE OF CORONER [Faint text]		87. SIGNATURE OF JURY [Faint text]		88. SIGNATURE OF DECEASED [Faint text]		89. SIGNATURE OF WITNESS [Faint text]		90. SIGNATURE OF PHYSICIAN [Faint text]	
91. SIGNATURE OF MINISTER OF RELIGION [Faint text]		92. SIGNATURE OF CORONER [Faint text]		93. SIGNATURE OF JURY [Faint text]		94. SIGNATURE OF DECEASED [Faint text]		95. SIGNATURE OF WITNESS [Faint text]	
96. SIGNATURE OF PHYSICIAN [Faint text]		97. SIGNATURE OF MINISTER OF RELIGION [Faint text]		98. SIGNATURE OF CORONER [Faint text]		99. SIGNATURE OF JURY [Faint text]		100. SIGNATURE OF DECEASED [Faint text]	

BUREAU V. 3

SEP 9 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09432

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9426

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X/ Cambridge - Rural</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge-Maryland Hospital</u>				d. STREET ADDRESS <u>R.F.D. #3</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Johnson</u> Last <u>Brannock</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-13-87</u>		9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Phillip Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Sadie Palmer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Carroll Brannock</u> Address <u>Cambridge, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic hypertensive cardio vascular</u> DUE TO (c) <u>renal disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 mins</u> <u>Approx. 5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Severe osteo-arthritis and intertrochanteric fracture of left hip</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Patient fell in own home on 8-30-57</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>8-30-57 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>own home</u>		20f. (City or town) (County) (State) <u>Cambridge Dorchester Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Eldridge H. Wolff</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9-19-57</u>	
EXAMINER'S NAME (Type) <u>Eldridge H. Wolff, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-21-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				ADDRESS <u>Cambridge, Maryland</u>		24a. REC'D BY REGISTRAR <u>John Mace Jr.</u>	
				24b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



RECEIVED

SEP 24 1957

BUREAU VI

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: \_\_\_\_\_  
2. SEX: \_\_\_\_\_  
3. AGE: \_\_\_\_\_  
4. DATE OF DEATH: \_\_\_\_\_  
5. PLACE OF DEATH: \_\_\_\_\_  
6. CAUSE OF DEATH: \_\_\_\_\_  
7. MANNER OF DEATH: \_\_\_\_\_  
8. SIGNATURE OF EXAMINER: \_\_\_\_\_  
9. SIGNATURE OF ATTENDING PHYSICIAN: \_\_\_\_\_  
10. SIGNATURE OF CORONER: \_\_\_\_\_  
11. SIGNATURE OF JURY: \_\_\_\_\_  
12. SIGNATURE OF DISTRICT ATTORNEY: \_\_\_\_\_  
13. SIGNATURE OF SHERIFF: \_\_\_\_\_  
14. SIGNATURE OF CLERK: \_\_\_\_\_  
15. SIGNATURE OF JUDGE: \_\_\_\_\_  
16. SIGNATURE OF JURY: \_\_\_\_\_  
17. SIGNATURE OF DISTRICT ATTORNEY: \_\_\_\_\_  
18. SIGNATURE OF SHERIFF: \_\_\_\_\_  
19. SIGNATURE OF CLERK: \_\_\_\_\_  
20. SIGNATURE OF JUDGE: \_\_\_\_\_

9441

## CERTIFICATE OF DEATH

09433

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u> 17X2.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Madeline S. Bryan</u>		4. DATE OF DEATH Month Day Year <u>Sept 26 1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 12 1886</u> 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTH PLACE (State or foreign country) <u>Berkeley Maryland</u>
13. FATHER'S NAME <u>James B. Starkey</u>		14. MOTHER'S MAIDEN NAME <u>Cora Hayes Watts</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u> 17. INFORMANT Address <u>Hospital Records Cambridge Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>UNK</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 15 1952</u> , to <u>Sept 26 1957</u> , that I last saw the deceased alive on <u>Sept 26 1957</u> , and that death occurred at <u>6:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas J. Dredge</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>State Hospital Cambridge 9-26-57</u>	
PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 28-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chestnutfield</u>	22d. LOCATION (City, town, or county) (State) <u>Centreville Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Butler Jr of Butler Bros. Centreville Md.</u>		24a. REC'D BY REGISTRAR DATE <u>9/30/57</u>	24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09434

Reg. Dist. No.

9427

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			c. LENGTH OF STAY IN 1b <b>5 hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hurlock</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge-Maryland Hospital</b>				d. STREET ADDRESS <b>7</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Susie</b> Middle <b>Anna</b> Last <b>Coleman</b>				4. DATE OF DEATH Month <b>September</b> Day <b>9</b> Year <b>1957</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 6, 1885</b>		
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min. <b>72</b>		IF UNDER 24 HRS. Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min. <b>72</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Harris</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ann Cephas</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-07-3458</b>		17. INFORMANT <b>Mrs. Edith Henry, East New Market, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John Mace Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) <b>Dr. John Mace Jr.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>9/10/57</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 12, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Federal Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Federalsburg, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b>				ADDRESS <b>Maryland</b>		24a. REC'D BY REGISTRAR <b>9/10/57</b>		
				24b. REGISTRAR'S SIGNATURE <i>John Mace Jr.</i>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

SEP 16 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09435

9442

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>6 mo. 5 mo. 3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS <u>-</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>F.</u> Last <u>Cowan</u>		4. DATE OF DEATH Month <u>September</u> Day <u>17</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-5-72</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>7</u> Hours <u>X</u> Min. <u>2.2</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>7</u> Hours <u>X</u> Min. <u>2.2</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Cowan</u>		14. MOTHER'S MAIDEN NAME <u>Ruby Godelle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>RECORDS: Eastern Shore State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mitral Stenosis</u> DUE TO (b) <u>Lobar Pneumonia</u> DUE TO (c) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>490x Senile Psychosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4-25</u> , 19 <u>57</u> , to <u>9-17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9-16</u> , 19 <u>57</u> , and that death occurred at <u>2:20A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Harry J. Crawford</u> M.D. PHYSICIAN'S NAME (Type) <u>Harry J. Crawford</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>9/20/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hopeville</u>	22d. LOCATION (City, town, or county) (State) <u>Port Deposit Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Corneille Funerary, Cambridge</u>		24a. REC'D BY REGISTRAR DATE <u>9/18/57</u>	24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>

SEP 24 1957

BUREAU V. B.

RECEIVED

9443

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS <u>R.F.D. 4</u>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Peter</u> Last <u>Dvorak</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5 1874</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>James Dvorak</u>				14. MOTHER'S MAIDEN NAME <u>Kathern Vrana</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-243313</u>		17. INFORMANT <u>Hospital Records Cambridge Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>391X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>unk.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Sept 11</u> 19 <u>56</u> , to <u>Sept 16</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 15</u> 19 <u>57</u> , and that death occurred at <u>4:35 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Thomas J. Dredge M.D. State Hosp, Cambridge Md</u> 9-16-57 PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cemetery</u>		22d. LOCATION (City, town, or county) <u>Elkton, Md</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service Cambridge Md</u>				24a. REC'D BY REGISTRAR <u>John Mace Jr.</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		AGE	
SEX		RACE	
BIRTH DATE		BIRTH PLACE	
EDUCATION		OCCUPATION	
MARRIAGE		RELIGION	
PREVIOUS ILLNESS		TREATMENT	
HISTORY		FAMILY HISTORY	
SOCIAL HISTORY		HABITS	
DIET		EXERCISE	
SMOKING		ALCOHOL	
DRUGS		ALLERGIES	
VACCINATIONS		LABORATORY TESTS	
X-RAYS		PATHOLOGICAL FINDINGS	
AUTOPSY		FORENSIC FINDINGS	
BURIAL		CEREMONY	
FUNERAL HOME		COST	
CITY		COUNTY	
STATE		COUNTRY	

BUREAU V. S.

SEP 24 1957

RECEIVED

9428

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gambroge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Free Point</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stagion Nursing Home</u>				d. STREET ADDRESS <u>17x2.2</u>			
3. NAME OF DECEASED (Type or print) <u>Charles James Fleckenstein</u>				4. DATE OF DEATH <u>9/13/57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/24/1879</u>	
9. AGE (In years and birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.		12. MONTHS <u>13</u> DAYS <u>01</u> HOURS <u>19</u> MIN.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>tailor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Comfort</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George Fleckenstein</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Muthaupt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>111-13-10000</u>			
17. INFORMANT <u>Dr. B. Hampton, E. H. Markel</u>				Address <u>111-13-10000</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis C.V. disease</u> DUE TO (c) <u>?</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Enter Colitis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>9/13/57</u> 19 <u>57</u> , to <u>9/13/57</u> 19 <u>57</u> , that I last saw the deceased alive on <u>9/13/57</u> , 19 <u>57</u> , and that death occurred at <u>10 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John Mace Jr</u> M.D.				ADDRESS (Street, city or town, state) <u>6 Church St. Cambridge Maryland</u>			
DATE SIGNED <u>10/1/57</u>							
PHYSICIAN'S NAME (Type) <u>JOHN MACE JR</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>10/3/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenston Catholic</u>		22d. LOCATION (City, town, or county) (State) <u>Greenston Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Willie H. Halloway, E. H. Markel</u>				24. REC'D BY REGISTRAR <u>DATE 10/1/57</u>			
24b. REGISTRAR'S SIGNATURE <u>James</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, and cause of death. The form is mostly blank with some faint handwriting.

Autism Spectrum Disorder  
Mental

Autism Spectrum Disorder

1/30/21  
John MacFar  
10/11/21  
BUREAU V. S.  
RECEIVED  
OCT 7 1921

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit 07x2.2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>L</u> Last <u>Grant</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	11. BIRTH PLACE (State or foreign country) <u>U.S.A.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles Grant</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Fuller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hospital Records Cambridge Md</u>	
17. INFORMANT Address <u>Hospital Records Cambridge Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Haemorrhage</u> 331X DUE TO (b) <u>Unk.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Dec 15, 1953</u> , to <u>Sept 16, 1957</u> , that I last saw the deceased alive on <u>Sept 15, 1957</u> , and that death occurred at <u>2:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas J. Dredge</u> M.D.		ADDRESS (Street, city or town, state) <u>State Hosp, Cambridge Md</u> DATE SIGNED <u>9-16-57</u>	
PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-14-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester</u>	22d. LOCATION (City, town, or county) (State) <u>Port Deposit, Md. Rural</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leola Patterson &amp; Son, Perryville, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>9/17/57</u>	24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 24 1957

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18



9445

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge (Rural)</u>				c. LENGTH OF STAY IN IB <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.F.D. #3</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Vernon</u> Middle <u>Hamilton</u> Last <u>Hamilton</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 14, 1888</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>69</u> Days <u>69</u> Hours <u>69</u> Min. <u>69</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Cyrus Hamilton</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Ward</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Lydia Hamilton, R.F.D. #3 Cambridge, Md.</u>		17. INFORMANT <u>Lydia Hamilton, R.F.D. #3 Cambridge, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis acute</u> DUE TO <u>Arterio-sclerosis C.V.D.</u> DUE TO <u>Arterio-sclerosis gen + hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Psychosis, senile</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2-3 hrs</u> <u>P</u> <u>P</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug</u> 19 <u>57</u> , to <u>Sept 12</u> , 19 <u>57</u> that I last saw the deceased alive on <u>Sept 4</u> , 19 <u>57</u> , and that death occurred at <u>5 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. H. Thompson</u> M.D.				DATE SIGNED <u>Sept 13, 1957</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/15/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Beckwith Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>R.F.D. #3, Cambridge, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. H. H. H.</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>9/13/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>John H. H. H.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU V. S.

SEP 16 1967

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1809440

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9429 Item 9 Film G221 10-11-57 et

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Dorchester Co.</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> <span style="float: right;">b. COUNTY <u>Dorchester Co.</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>			c. LENGTH OF STAY IN 1b <u>5 Yr.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u> <u>13</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Water St.</u>				d. STREET ADDRESS <u>Water St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Blanche</u> Middle <u>Tomlinson</u> Last <u>Hicks</u>				<b>4. DATE OF DEATH</b> Month <u>Sept.</u> Day <u>11</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/15/1903</u>		9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months Days Hours Mln.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Store</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John H. Tomlinson</u>				14. MOTHER'S MAIDEN NAME <u>Kate Cordrey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-10-9662</u>		17. INFORMANT <u>Mrs. Paul Irvin</u> <u>Ocean City Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cause undetermined</u> <u>795.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause lost. DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .							
ACTUAL SIGNATURE <u>Eldridge H. Wolff</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9-16-57</u>	
EXAMINER'S NAME (Type) <u>Eldridge H. Wolff, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/17/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				ADDRESS <u>Cambridge Md.</u>		24a. REC'D BY REGISTRAR DATE <u>9/18/57</u>	
24b. REGISTRAR'S SIGNATURE <u>John M. ...</u>				24c. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# STATE DEPARTMENT OF HEALTH - BALTIMORE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

OCT 2 1957

RECEIVED

## 9446 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hurlock - Rural</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lou</b> Middle <b>Rena</b> Last <b>Hudson</b>		4. DATE OF DEATH Month <b>September</b> Day <b>7</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 22, 1881</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Levin L. Fletcher</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Walter C. Hudson, Hurlock, Md., R.F.D.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Coronary Heart Failure</b> DUE TO <b>442X</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b> (c) <b>Arteriosclerosis (Generalized)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 y 12</b> <b>?</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/4</b> , 19 <b>57</b> , to <b>9/7</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>9/7</b> , 19 <b>57</b> , and that death occurred at <b>8:45 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Harold B. Plummer</b>		ADDRESS (Street, city or town, state) <b>Preston, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Harold B. Plummer, M.D.</b>		DATE SIGNED <b>9/8/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 10, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Washington Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Near Hurlock, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b>		24a. REC'D BY REGISTRAR <b>SEP 11 '57</b>	
24b. REGISTRAR'S SIGNATURE <b>Paul...</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

SEP 11 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

Item 18 Film 221 10-3-57 ans									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 09442									
1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN 1b <b>10 yrs.</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 Cambridge</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge-Maryland Hospital</b>					d. STREET ADDRESS <b>78 Washington St.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Louise</b> First <b>Hyland</b> Middle <b>Sept.</b> Last <b>17</b> Day <b>19</b> Year <b>57</b>					4. DATE OF DEATH				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 3, 1920</b>		9. AGE (In years last birthday) <b>37</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Any labor</b>		11. BIRTHPLACE (State or foreign country) <b>Seaford, Del.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Sylvester Staten</b>					14. MOTHER'S MAIDEN NAME <b>Mary Tingle</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>221 12 4199</b>		17. INFORMANT <b>Hospital Records, Cambridge, Md.</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Strangulation</b> <b>921.7</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Aspiration gastric contents</b> (c), stating the underlying cause last. DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Gangrene loop of small bowel due to hernia, umbilical</b>									
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Aspirated gastric contents on operating table.</b>							
20c. TIME OF INJURY Month, Day, Year <b>2.20 PM 9/17/57</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) <b>Cambridge</b> (County) <b>Dor.</b> (State) <b>Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>John Mace Jr.</b>		EXAMINER'S NAME (Type) <b>John Mace Jr.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/21/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Concord Cemetery</b>		22d. LOCATION (City, town, or county) <b>Concord, Del.</b> (State)		DATE SIGNED <b>9/18/57</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Herbert St. Clair</b> ADDRESS <b>Cambridge, Md.</b>				24a. REC'D BY REGISTRAR <b>9/25/57</b>		24b. REGISTRAR'S SIGNATURE <b>John Mace Jr.</b>			

67

1

09

2

MINNESOTA STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

SEP 30 1957

RECEIVED

9431

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishops Head Md.</u>			
c. LENGTH OF STAY IN 1b <u>3 Days</u>				d. STREET ADDRESS <u>1 Bishops Head Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Md. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Floyetta</u> Middle <u>Bramble</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>28</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/29/1884</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Bishops Head</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bushrod Bramble</u>				14. MOTHER'S MAIDEN NAME <u>Melvina Wingate</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Kathleen Abbott</u> Address <u>Bishops Head Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL FAILURE</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROSIS.</u> DUE TO (c) <u>CHR. NEPHRITIS</u> <u>Acute Nephritis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHOLELITHIASIS</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>9/24</u> , 19 <u>57</u> , to <u>9/28</u> , 19 <u>57</u> ; that I last saw the deceased alive on <u>9/28</u> , 19 <u>57</u> , and that death occurred at <u>2 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city or town, state) <u>104 Locust</u> DATE SIGNED <u>9/29/57</u>			
PHYSICIAN'S NAME (Type) <u>W. H. HANKS</u>				<u>CAMBRIDGE Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/30/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				ADDRESS <u>Cambridge Md.</u>		24a. REC'D BY REGISTRAR DATE <u>10/1/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>John Mave Jr.</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. B.

OCT 2 1957

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9432

## CERTIFICATE OF DEATH

Reg. Dist. No. 09444

1. PLACE OF DEATH o. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN 1b <b>12 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4 Colemans Alley</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Irene</b> Middle <b>Oatman</b> Last <b>Jordan</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>27</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 11, 1888</b>	
9. AGE (In years last birthday) <b>69 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		11. BIRTHPLACE (State or foreign country) <b>Augusta, Ga.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Paterson</b>				14. MOTHER'S MAIDEN NAME <b>Lucy Paterson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>252-28-8094</b>		17. INFORMANT <b>Thomas Jordan, Cambridge, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> 260x DUE TO (b) <b>Arterio-sclerotic CVD</b> DUE TO (c) <b>Adverse Diabetes mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arterio-sclerotic</b>						INTERVAL BETWEEN ONSET AND DEATH <b>acute</b> <b>?</b> <b>?</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Thompson</b>				DATE SIGNED <b>Cambridge, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Thompson</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10/3/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Preston Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Preston, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. ...</b>				24a. REC'D BY REGISTRAR <b>DATE 10/3/57</b>		24b. REGISTRAR'S SIGNATURE <b>John M. ...</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU V. S.**

OCT 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9447

## CERTIFICATE OF DEATH

Reg. Dist. No.

09445

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge RFD # 1</u>				c. LENGTH OF STAY IN 1b <u>13 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge RFD #1</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lucy</u> Middle <u>Glaser</u> Last <u>King</u>				4. DATE OF DEATH Month <u>9</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/12/1861</u>	
9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Oak Harbor, Ill.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>George Glaser</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Schramm</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. A. W. Baldwin</u> Address <u>RFD # 3; Cambridge, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage.</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerosis -</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>14 Days</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>							
21. I certify that I attended the deceased from <u>June</u> , 19 <u>52</u> , to <u>Sept</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 5</u> , 19 <u>57</u> , and that death occurred at <u>7 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Albert E. Bunker M.D.</u>				ADDRESS (Street, city or town, state) <u>200 Maryland Ave, Cambridge Md.</u>			
DATE SIGNED <u>9/7/57</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/11/57.</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sylvania, Ill.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>9/11/57</u>		24b. REGISTRAR'S SIGNATURE <u>John M...</u>	

BUREAU V. E.

SEP 16 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9448

## CERTIFICATE OF DEATH

09446

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge 13</u>			
d. NAME OF HOSPITAL (If not in-hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS <u>U</u>			
3. NAME OF DECEASED (Type or print) <u>John E. Knox</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>DIVORCED</u>	8. DATE OF BIRTH <u>Nov 28 1877</u>		9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Robert Knox</u>			
14. MOTHER'S MAIDEN NAME <u>Sally Hignott</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT <u>Hospital Records Cambridge Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>May 3, 1952</u> , to <u>Sept 11, 1957</u> , that I last saw the deceased alive on <u>Sept 11, 1957</u> , and that death occurred at <u>9:40 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas J. Dredge</u> M.D.				ADDRESS (Street, city or town, state) <u>S.H. Cambridge Md</u>			
DATE SIGNED <u>9-11-57</u>							
PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge Cambridge Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 13, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christfield Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Barton of Barton Bros. Centerville, MD</u>				ADDRESS _____		24a. REC'D BY REGISTRAR <u>John Mace Jr.</u>	
DATE <u>9/16/57</u>				24b. REGISTRAR'S SIGNATURE			



CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
1878		Bath	
TIME OF DEATH		CAUSE OF DEATH	
10:00 AM		Drowning	
AGE		SEX	
18		Male	
NAME		RESIDENCE	
John Smith		Boston, Mass.	
OCCUPATION		PROFESSION	
Seaman		None	
MARRIED		SINGLE	
Yes		No	
WITNESSES		SIGNATURE	
J. A. Smith		J. A. Smith	
J. B. Smith		J. B. Smith	
J. C. Smith		J. C. Smith	
J. D. Smith		J. D. Smith	
J. E. Smith		J. E. Smith	
J. F. Smith		J. F. Smith	
J. G. Smith		J. G. Smith	
J. H. Smith		J. H. Smith	
J. I. Smith		J. I. Smith	
J. J. Smith		J. J. Smith	
J. K. Smith		J. K. Smith	
J. L. Smith		J. L. Smith	
J. M. Smith		J. M. Smith	
J. N. Smith		J. N. Smith	
J. O. Smith		J. O. Smith	
J. P. Smith		J. P. Smith	
J. Q. Smith		J. Q. Smith	
J. R. Smith		J. R. Smith	
J. S. Smith		J. S. Smith	
J. T. Smith		J. T. Smith	
J. U. Smith		J. U. Smith	
J. V. Smith		J. V. Smith	
J. W. Smith		J. W. Smith	
J. X. Smith		J. X. Smith	
J. Y. Smith		J. Y. Smith	
J. Z. Smith		J. Z. Smith	

BUREAU V. 3

SEP 04 1957

RECEIVED

9433

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>60 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>304 Locust Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>David</b> Middle <b>Allen</b> Last <b>Messick, Sr.</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>3</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 15, 1873</b>
9. AGE (In years (by birthday) yrs. <b>84</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retires Wasserman self-employed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Smith Island, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Allen Messick</b>		14. MOTHER'S MAIDEN NAME <b>Helen L. Tyler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Emmett Messick, 304 Locust St., Cambridge, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>GENERAL ARTERIOSCLEROSIS</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>4 YEARS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/12</b> , 19 <b>57</b> to <b>9/3</b> , 19 <b>57</b> that I last saw the deceased alive on <b>9/2</b> , 19 <b>57</b> and that death occurred at <b>11:15 P.M.</b> from the causes and on the date stated above.		DATE SIGNED <b>4 SEPT 57</b>	
ACTUAL SIGNATURE <b>Walter E. Gunby Jr</b> M.D.		ADDRESS (Street, city or town, state) <b>Cambridge Md.</b>	
PHYSICIAN'S NAME (Type) <b>WALTER E. GUNBY JR</b>		<b>105 CHURCH ST.</b>	
22a. BURIAL, CREMATION, REBURY (Specify) <b>Buried</b>	22b. DATE THEREOF <b>Sept. 6, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth R. Thomas</b> ADDRESS <b>Cambridge, Md.</b>		24a. REC'D BY REGISTRAR <b>9/7/57</b>	24b. REGISTRAR'S SIGNATURE <b>John Mace</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page One of Two

1. NAME OF DECEASED <b>JOHN J. BROWN</b>		2. SEX <b>Male</b>	
3. DATE OF BIRTH <b>March 15, 1901</b>		4. PLACE OF BIRTH <b>St. Louis, Mo.</b>	
5. DATE OF DEATH <b>March 15, 1957</b>		6. PLACE OF DEATH <b>St. Louis, Mo.</b>	
7. TIME OF DEATH <b>10:15 P.M.</b>		8. CAUSE OF DEATH <b>Myocardial Infarction</b>	
9. MANNER OF DEATH <b>Natural</b>		10. PLACE OF INTERMENT <b>St. Louis, Mo.</b>	
11. SIGNATURE OF DECEASED <b>John J. Brown</b>		12. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
13. SIGNATURE OF DECEASED <b>John J. Brown</b>		14. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
15. SIGNATURE OF DECEASED <b>John J. Brown</b>		16. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
17. SIGNATURE OF DECEASED <b>John J. Brown</b>		18. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
19. SIGNATURE OF DECEASED <b>John J. Brown</b>		20. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
21. SIGNATURE OF DECEASED <b>John J. Brown</b>		22. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
23. SIGNATURE OF DECEASED <b>John J. Brown</b>		24. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
25. SIGNATURE OF DECEASED <b>John J. Brown</b>		26. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
27. SIGNATURE OF DECEASED <b>John J. Brown</b>		28. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
29. SIGNATURE OF DECEASED <b>John J. Brown</b>		30. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
31. SIGNATURE OF DECEASED <b>John J. Brown</b>		32. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
33. SIGNATURE OF DECEASED <b>John J. Brown</b>		34. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
35. SIGNATURE OF DECEASED <b>John J. Brown</b>		36. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
37. SIGNATURE OF DECEASED <b>John J. Brown</b>		38. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
39. SIGNATURE OF DECEASED <b>John J. Brown</b>		40. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
41. SIGNATURE OF DECEASED <b>John J. Brown</b>		42. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
43. SIGNATURE OF DECEASED <b>John J. Brown</b>		44. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
45. SIGNATURE OF DECEASED <b>John J. Brown</b>		46. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
47. SIGNATURE OF DECEASED <b>John J. Brown</b>		48. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
49. SIGNATURE OF DECEASED <b>John J. Brown</b>		50. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
51. SIGNATURE OF DECEASED <b>John J. Brown</b>		52. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
53. SIGNATURE OF DECEASED <b>John J. Brown</b>		54. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
55. SIGNATURE OF DECEASED <b>John J. Brown</b>		56. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
57. SIGNATURE OF DECEASED <b>John J. Brown</b>		58. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
59. SIGNATURE OF DECEASED <b>John J. Brown</b>		60. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
61. SIGNATURE OF DECEASED <b>John J. Brown</b>		62. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
63. SIGNATURE OF DECEASED <b>John J. Brown</b>		64. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
65. SIGNATURE OF DECEASED <b>John J. Brown</b>		66. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
67. SIGNATURE OF DECEASED <b>John J. Brown</b>		68. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
69. SIGNATURE OF DECEASED <b>John J. Brown</b>		70. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
71. SIGNATURE OF DECEASED <b>John J. Brown</b>		72. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
73. SIGNATURE OF DECEASED <b>John J. Brown</b>		74. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
75. SIGNATURE OF DECEASED <b>John J. Brown</b>		76. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
77. SIGNATURE OF DECEASED <b>John J. Brown</b>		78. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
79. SIGNATURE OF DECEASED <b>John J. Brown</b>		80. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
81. SIGNATURE OF DECEASED <b>John J. Brown</b>		82. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
83. SIGNATURE OF DECEASED <b>John J. Brown</b>		84. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
85. SIGNATURE OF DECEASED <b>John J. Brown</b>		86. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
87. SIGNATURE OF DECEASED <b>John J. Brown</b>		88. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
89. SIGNATURE OF DECEASED <b>John J. Brown</b>		90. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
91. SIGNATURE OF DECEASED <b>John J. Brown</b>		92. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
93. SIGNATURE OF DECEASED <b>John J. Brown</b>		94. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
95. SIGNATURE OF DECEASED <b>John J. Brown</b>		96. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
97. SIGNATURE OF DECEASED <b>John J. Brown</b>		98. SIGNATURE OF WITNESSES <b>John J. Brown</b>	
99. SIGNATURE OF DECEASED <b>John J. Brown</b>		100. SIGNATURE OF WITNESSES <b>John J. Brown</b>	

**RECEIVED**  
 SEP 9 1957  
 BUREAU V. S.

9449

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FEDERALSBURG</u> <u>05X2.2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CLARENCE EDWIN NICHOLS</u>				4. DATE OF DEATH <u>SEPT 4 1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 26, 1875</u>	9. AGE (In years last birthday) <u>82 yrs.</u>	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER-CLERK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HARDWARE STORE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>FRANCIS NICHOLS</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA TAYLOR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>MRS. W. VINCENT MCCREA</u> Address <u>FEDERALSBURG, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>177X CORONARY OCCLUSION</u> DUE TO (b) <u>MITRAL STENOSIS</u> DUE TO (c) <u>CARCINOMA OF PROSTATE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>4 HRS.</u> <u>24 HRS.</u> <u>OVER 1 WEEK</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIO-SCLEROSIS</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>APRIL 25, 1957</u> to <u>SEPT 4, 1957</u> , that I last saw the deceased alive on <u>SEPT 4, 1957</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Harry J Crawford</u>				M.D. <u>ESS HOSP-CAMBRIDGE, MD</u> <u>SEPT 4, 1957</u>			
PHYSICIAN'S NAME (Type) <u>HARRY J CRAWFORD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 6, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HILL CREST CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>FEDERALSBURG, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Thompson</u> ADDRESS <u>Federalburg Md.</u>				24a. REC'D BY REGISTRAR <u>9/6/57</u>		24b. REGISTRAR'S SIGNATURE <u>John M. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 9 1957

RECEIVED



9450

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Galestown</b>				c. LENGTH OF STAY IN 1b <b>4 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>David</b> Last <b>Patton</b>				4. DATE OF DEATH Month <b>September</b> Day <b>23</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 5, 1904</b>		9. AGE (In years last birthday) <b>53</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Chef</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Del. State Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>Marietta, Miss.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William P. Patton</b>				14. MOTHER'S MAIDEN NAME <b>Virginia Tyra</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>222-22-4896</b>		17. INFORMANT Address <b>Mrs. Elma M. Patton, Seaford, Del., R.F.D.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain Tumor</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 1957, to <b>Sept 23</b> , 1957, that I last saw the deceased alive on <b>Sept 22</b> , 1957, and that death occurred at <b>6:25 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>H. S. Kuhlman</b> M.D.				ADDRESS (Street, city or town, state) <b>Sharpton Rd</b>		DATE SIGNED <b>9/25/57</b>	
PHYSICIAN'S NAME (Type) <b>H. S. Kuhlman</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 27, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gracelawn Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Wilmington, Delaware</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Frampton and Son, Federalsburg, Maryland</b>				24a. REC'D BY REGISTRAR <b>DATE SEP 30 '57</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BOKEAD V. 3.

3. A review of the literature on the effects of the environment on human health and the environment on human health.

\_\_\_\_\_

05 AUG 1981

DEC 19 1964

\_\_\_\_\_

---

---

BUREAU V. S.

SEP 30 1957

RECEIVED

Kent

(If outside limits, write RURAL and give nearest town)

 $14 \times 2.2$ 

d. STREET ADDRESS

ON A FARM? YES ☐ NO ☒

Year

1957

EAR 15 UNDER 24 HRS

YEAR	IF UNDER 24 HRS.	
ys	Hours	Min.

12. CITIZEN OF WHAT COUNTRY?

U.S.

Mollie Copper

Address \_\_\_\_\_

Eastern Shore State Hospital records

INTERVAL BETWEEN

## ONSET AND DEATH

**DUE TO**

(b)  
DUE TO  
(c)

19. WAS AUTOPSY

19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20f. (City or town)

(County)

(State)

DATE SIGNED \_\_\_\_\_

M.D. E. S. S. Hospital, Cambridge, Md. 9/27/57

Thomas J. Dredge, M.D.

22d LOCATION (City, town, or county)

151-1-1

26 REC'D BY REGISTRAR

24. REGISTRAR'S SIGNATURE \_\_\_\_\_

VS A15 (4)  
15M 9/55

RECEIVED  
SEP 30 1957  
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9452

CERTIFICATE OF DEATH

09451 116

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Cambridge</u>				c. LENGTH OF STAY IN 1b <u>17 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>VIRGINIA PEARL REID</u>				4. DATE OF DEATH Month Day Year <u>Sept. 27 19 57</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>7/12/93</u>		9. AGE (In years last birthday) yrs. <u>64</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Elton James Reid</u>				14. MOTHER'S MAIDEN NAME <u>Mary V. Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Eastern Shore State Hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of the face</u> <u>191x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mental Deficiency, without psychosis, moron</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec. 15</u> , 19 <u>52</u> , to <u>Sept. 27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept. 27</u> , 19 <u>57</u> , and that death occurred at <u>11:40 M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Thomas J. Dredge</u> M.D. <u>E.S.S. Hospital, Cambridge, Md.</u> PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-29-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Gunby Presbyterian</u>		22d. LOCATION (City, town, or county) (State) <u>Stockton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry B. Watson</u>				24. REC'D BY REGISTRAR <u>SEP 30 1957</u>		25. REGISTRAR'S SIGNATURE <u>John Macey Jr.</u>	



CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. MEDICAL HISTORY		15. PREVIOUS ILLNESS		16. PREVIOUS SURGERY	
17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF REGISTRAR		19. SIGNATURE OF WITNESS		20. SIGNATURE OF DECEASED		21. SIGNATURE OF NEXT OF KIN		22. SIGNATURE OF CLERGYMAN		23. SIGNATURE OF JUDGE		24. SIGNATURE OF JURY	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF NEXT OF KIN		27. SIGNATURE OF CLERGYMAN		28. SIGNATURE OF JUDGE		29. SIGNATURE OF JURY		30. SIGNATURE OF DECEASED		31. SIGNATURE OF NEXT OF KIN		32. SIGNATURE OF CLERGYMAN	
33. SIGNATURE OF JUDGE		34. SIGNATURE OF JURY		35. SIGNATURE OF DECEASED		36. SIGNATURE OF NEXT OF KIN		37. SIGNATURE OF CLERGYMAN		38. SIGNATURE OF JUDGE		39. SIGNATURE OF JURY		40. SIGNATURE OF DECEASED	
41. SIGNATURE OF NEXT OF KIN		42. SIGNATURE OF CLERGYMAN		43. SIGNATURE OF JUDGE		44. SIGNATURE OF JURY		45. SIGNATURE OF DECEASED		46. SIGNATURE OF NEXT OF KIN		47. SIGNATURE OF CLERGYMAN		48. SIGNATURE OF JUDGE	
49. SIGNATURE OF JURY		50. SIGNATURE OF DECEASED		51. SIGNATURE OF NEXT OF KIN		52. SIGNATURE OF CLERGYMAN		53. SIGNATURE OF JUDGE		54. SIGNATURE OF JURY		55. SIGNATURE OF DECEASED		56. SIGNATURE OF NEXT OF KIN	
57. SIGNATURE OF CLERGYMAN		58. SIGNATURE OF JUDGE		59. SIGNATURE OF JURY		60. SIGNATURE OF DECEASED		61. SIGNATURE OF NEXT OF KIN		62. SIGNATURE OF CLERGYMAN		63. SIGNATURE OF JUDGE		64. SIGNATURE OF JURY	
65. SIGNATURE OF DECEASED		66. SIGNATURE OF NEXT OF KIN		67. SIGNATURE OF CLERGYMAN		68. SIGNATURE OF JUDGE		69. SIGNATURE OF JURY		70. SIGNATURE OF DECEASED		71. SIGNATURE OF NEXT OF KIN		72. SIGNATURE OF CLERGYMAN	
73. SIGNATURE OF JUDGE		74. SIGNATURE OF JURY		75. SIGNATURE OF DECEASED		76. SIGNATURE OF NEXT OF KIN		77. SIGNATURE OF CLERGYMAN		78. SIGNATURE OF JUDGE		79. SIGNATURE OF JURY		80. SIGNATURE OF DECEASED	
81. SIGNATURE OF NEXT OF KIN		82. SIGNATURE OF CLERGYMAN		83. SIGNATURE OF JUDGE		84. SIGNATURE OF JURY		85. SIGNATURE OF DECEASED		86. SIGNATURE OF NEXT OF KIN		87. SIGNATURE OF CLERGYMAN		88. SIGNATURE OF JUDGE	
89. SIGNATURE OF JURY		90. SIGNATURE OF DECEASED		91. SIGNATURE OF NEXT OF KIN		92. SIGNATURE OF CLERGYMAN		93. SIGNATURE OF JUDGE		94. SIGNATURE OF JURY		95. SIGNATURE OF DECEASED		96. SIGNATURE OF NEXT OF KIN	
97. SIGNATURE OF CLERGYMAN		98. SIGNATURE OF JUDGE		99. SIGNATURE OF JURY		100. SIGNATURE OF DECEASED		101. SIGNATURE OF NEXT OF KIN		102. SIGNATURE OF CLERGYMAN		103. SIGNATURE OF JUDGE		104. SIGNATURE OF JURY	

BUREAU V. S.

SEP 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09452

9453

## CERTIFICATE OF DEATH

Reg. Dist. No.

116

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Galestown</b>		c. LENGTH OF STAY IN 1b <b>45 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Nettie</b> Middle <b>Reynolds</b> Last <b>Reynolds</b>		4. DATE OF DEATH Month <b>September</b> Day <b>12</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 29, 1895</b>
9. AGE (In years last birthday) <b>61 yrs.</b>		10. IF UNDER 1 YEAR: Months <b>61</b> Days <b>12</b> Hours <b>19</b> Min. <b>57</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Covington, Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Paul B. Reynolds</b>		14. MOTHER'S MAIDEN NAME <b>Sadie B. Thompson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Myrtle Calloway, Seaford, Del., R.F.D.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rheumatoid Arthritis</b> <b>722.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Secondary Anemia</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b> <b>6 months</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 11, 1957</b> to <b>Sept 12, 1957</b> , that I last saw the deceased alive on <b>Sept 11, 1957</b> , and that death occurred at <b>6 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H. S. Kuhn</b>		DATE SIGNED <b>9/14/57</b>	
PHYSICIAN'S NAME (Type) <b>H. S. Kuhn</b>		ADDRESS (Street, city or town, state) <b>Seaford, Del.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 15, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cokesburg Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Dorchester County, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Frampton and Son, Federalburg, Maryland</b>		24a. REC'D BY REGISTRAR <b>SEP 17 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>John M. ...</b>			

CERTIFICATE OF DEATH

DECEASED NAME JAMES E. HARRIS		SEX Male		AGE 68	
DATE OF DEATH 10-1-57		TIME OF DEATH 11:30 AM		PLACE OF DEATH Home	
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		PLACE OF BIRTH Baltimore, Md.	
OCCUPATION Retired		MARITAL STATUS Married		EDUCATION High School	
PREVIOUS ILLNESS None		MEDICAL HISTORY None		HUSBAND'S NAME Mary E. Harris	
SIGNATURE OF PHYSICIAN J. E. Harris		SIGNATURE OF DECEASED J. E. Harris		SIGNATURE OF WITNESS J. E. Harris	
DATE OF SIGNATURE 10-1-57		DATE OF SIGNATURE 10-1-57		DATE OF SIGNATURE 10-1-57	
PLACE OF SIGNATURE Baltimore, Md.		PLACE OF SIGNATURE Baltimore, Md.		PLACE OF SIGNATURE Baltimore, Md.	
SIGNATURE OF DECEASED J. E. Harris		SIGNATURE OF WITNESS J. E. Harris		SIGNATURE OF WITNESS J. E. Harris	
DATE OF SIGNATURE 10-1-57		DATE OF SIGNATURE 10-1-57		DATE OF SIGNATURE 10-1-57	
PLACE OF SIGNATURE Baltimore, Md.		PLACE OF SIGNATURE Baltimore, Md.		PLACE OF SIGNATURE Baltimore, Md.	
SIGNATURE OF DECEASED J. E. Harris		SIGNATURE OF WITNESS J. E. Harris		SIGNATURE OF WITNESS J. E. Harris	
DATE OF SIGNATURE 10-1-57		DATE OF SIGNATURE 10-1-57		DATE OF SIGNATURE 10-1-57	
PLACE OF SIGNATURE Baltimore, Md.		PLACE OF SIGNATURE Baltimore, Md.		PLACE OF SIGNATURE Baltimore, Md.	

BUREAU V. S.

SEP 17 1957

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

09453  
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Cambridge</b>			c. LENGTH OF STAY IN lb <b>28 yrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Cambridge.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>1</b>			
3. NAME OF DECEASED (Type or print) First <b>Julius</b> Middle <b>Avery</b> Last <b>Saulsbury</b>				4. DATE OF DEATH Month <b>Sept</b> Day <b>18</b> Year <b>1957</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 20, 1895</b>		9. AGE (In years last birthday) <b>62</b> yrs.	
				IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Service Station.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gas and oil</b>		11. BIRTHPLACE (State or foreign country) <b>Talbot County, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>James Thomas Saulsbury</b>				14. MOTHER'S MAIDEN NAME <b>Josephine Berbidge</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-32-6332</b>		17. INFORMANT <b>Ruby Banning Saulsbury.</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John Mace Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>buried</b>		<b>Sept 16, 57</b>		<b>Spring Hill</b>		<b>Easton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert Earl</i>				ADDRESS <i>Easton Md</i>		24a. REC'D BY REGISTRAR DATE <b>9/14/57</b>	
				24b. REGISTRAR'S SIGNATURE <i>John Mace Jr.</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		35 yrs.	
Date of Death		Place of Death		Cause of Death	
Jan 15, 1957		Home		Heart Disease	
Time of Death		Manner of Death		Occupation	
10:00 AM		Natural		Teacher	
Residence		Usual Residence		Place of Burial	
123 Main St.		123 Main St.		Catholic Church	
City		County		State	
Baltimore		Baltimore		Maryland	
Signature of Examiner		Signature of Coroner		Signature of Physician	
[Signature]		[Signature]		[Signature]	

**RECEIVED**  
JAN 16 1957  
BUREAU





RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9456

CERTIFICATE OF DEATH

09456

Reg. Dist. No.

116

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS 20x2.2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>E</u> Last <u>Seymour</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>26</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 28 1881</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Seafarer</u>		11. BIRTHPLACE (State or foreign country) <u>St. Michaels Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H. Seymour</u>				14. MOTHER'S MAIDEN NAME <u>Clarissa Marshall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-34571</u>		17. INFORMANT Address <u>Hospital Records Cambridge Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Arteriosclerosis</u> <u>450.0</u> DUE TO: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>UNK</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>June 22, 1957</u> , to <u>Sept 26, 1957</u> , that I last saw the deceased alive on <u>Sept 26, 1957</u> , and that death occurred at <u>8:10 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Thomas J. Dredge</u> M.D.				State Hospital Cambridge Md			
PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>9/30/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>St. Michaels Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman D. Marshall - St Michaels</u>				24a. RECEIVED BY REGISTRAR DATE <u>Oct 1 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John Mue, Jr.</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		SERVICE		MILITARY		NAVY	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		MANNER OF DEATH		CAUSE OF DEATH	
DISEASE		SYMPTOMS		TREATMENT		DIAGNOSIS		PROGNOSIS		HISTORY		FAMILY HISTORY		PREVIOUS ILLNESS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	

BUREAU V. S.

OCT 1 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9457

CERTIFICATE OF DEATH

Reg. Dist. No.

09457

1. PLACE OF DEATH a. COUNTY <u>Norchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>14r 1Mo</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> <u>2040.2</u>		✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS <u>U</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Howard</u> First <u>T</u> Middle <u>Slaughter</u> Last				4. DATE OF DEATH <u>Sept</u> Month <u>1</u> Day <u>1957</u> Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1878</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer - Farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Employer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Hospital Records Cambridge Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Haemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 26, 1956</u> , to <u>Sept 1, 1957</u> , that I last saw the deceased alive on <u>Sept 1, 1957</u> , and that death occurred at <u>3:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thomas J. Dredge</u> M.D.				ADDRESS (Street, city or town, state) <u>Cambridge Md</u> DATE SIGNED <u>Sept 1 '57</u>			
PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Sept 4 57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Mace</u>				24a. REC'D BY REGISTRAR <u>SEP 3 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John Mace</u>	



RECEIVED

SEP 3 1957

BUREAU V. 3

1. NAME OF DECEASED		2. DATE OF DEATH	
3. PLACE OF DEATH		4. TIME OF DEATH	
5. SEX		6. AGE	
7. RACE		8. OCCUPATION	
9. MARITAL STATUS		10. CAUSE OF DEATH	
11. MANNER OF DEATH		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED	
15. SIGNATURE OF DECEASED		16. SIGNATURE OF DECEASED	
17. SIGNATURE OF DECEASED		18. SIGNATURE OF DECEASED	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF DECEASED	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF DECEASED	
23. SIGNATURE OF DECEASED		24. SIGNATURE OF DECEASED	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF DECEASED	
27. SIGNATURE OF DECEASED		28. SIGNATURE OF DECEASED	
29. SIGNATURE OF DECEASED		30. SIGNATURE OF DECEASED	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF DECEASED	
33. SIGNATURE OF DECEASED		34. SIGNATURE OF DECEASED	
35. SIGNATURE OF DECEASED		36. SIGNATURE OF DECEASED	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF DECEASED	
39. SIGNATURE OF DECEASED		40. SIGNATURE OF DECEASED	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF DECEASED	
43. SIGNATURE OF DECEASED		44. SIGNATURE OF DECEASED	
45. SIGNATURE OF DECEASED		46. SIGNATURE OF DECEASED	
47. SIGNATURE OF DECEASED		48. SIGNATURE OF DECEASED	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF DECEASED	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF DECEASED	
53. SIGNATURE OF DECEASED		54. SIGNATURE OF DECEASED	
55. SIGNATURE OF DECEASED		56. SIGNATURE OF DECEASED	
57. SIGNATURE OF DECEASED		58. SIGNATURE OF DECEASED	
59. SIGNATURE OF DECEASED		60. SIGNATURE OF DECEASED	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF DECEASED	
63. SIGNATURE OF DECEASED		64. SIGNATURE OF DECEASED	
65. SIGNATURE OF DECEASED		66. SIGNATURE OF DECEASED	
67. SIGNATURE OF DECEASED		68. SIGNATURE OF DECEASED	
69. SIGNATURE OF DECEASED		70. SIGNATURE OF DECEASED	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF DECEASED	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF DECEASED	
75. SIGNATURE OF DECEASED		76. SIGNATURE OF DECEASED	
77. SIGNATURE OF DECEASED		78. SIGNATURE OF DECEASED	
79. SIGNATURE OF DECEASED		80. SIGNATURE OF DECEASED	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF DECEASED	
83. SIGNATURE OF DECEASED		84. SIGNATURE OF DECEASED	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF DECEASED	
87. SIGNATURE OF DECEASED		88. SIGNATURE OF DECEASED	
89. SIGNATURE OF DECEASED		90. SIGNATURE OF DECEASED	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF DECEASED	
93. SIGNATURE OF DECEASED		94. SIGNATURE OF DECEASED	
95. SIGNATURE OF DECEASED		96. SIGNATURE OF DECEASED	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF DECEASED	
99. SIGNATURE OF DECEASED		100. SIGNATURE OF DECEASED	

CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

9434

## CERTIFICATE OF DEATH

09458

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>2 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 Cambridge</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge-Maryland Hospital</b>				d. STREET ADDRESS <b>514 Race St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Calvin</b> Last <b>Sparks</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>4</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 2, 1957</b>		9. AGE (In years last birthday) yrs. <b>2</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b>2</b> Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Cambridge</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Francis E. Sparks</b>				14. MOTHER'S MAIDEN NAME <b>Betty Wheeler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immaturity and Prematurity</b> <b>761.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>(28 weeks gestation)</b> DUE TO (c) <b>Premature Separation Placenta</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/4</b> , 19 <b>57</b> , to <b>9/4</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>9/4</b> , 19 <b>57</b> , and that death occurred at <b>12:30</b> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. H. Hanks</b>		M.D. <b>104 Locust St.</b>		ADDRESS (Street, city or town, state) <b>CAMBRIDGE MD</b>		DATE SIGNED <b>9/5/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 5, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth R. Thomas</b>				ADDRESS <b>Cambridge, Md.</b>		24a. REC'D BY REGISTRAR <b>7/7/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>John Nace Jr.</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2007233XVI

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
11. PLACE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESSES	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF CLERGYMAN		19. SIGNATURE OF BURIAL OFFICIAL		20. SIGNATURE OF FUNERAL HOME	
21. SIGNATURE OF CORONER		22. SIGNATURE OF JURY		23. SIGNATURE OF JUDGE		24. SIGNATURE OF SHERIFF		25. SIGNATURE OF CLERK	
26. SIGNATURE OF DECEASED		27. SIGNATURE OF NEXT OF KIN		28. SIGNATURE OF CLERGYMAN		29. SIGNATURE OF BURIAL OFFICIAL		30. SIGNATURE OF FUNERAL HOME	
31. SIGNATURE OF CORONER		32. SIGNATURE OF JURY		33. SIGNATURE OF JUDGE		34. SIGNATURE OF SHERIFF		35. SIGNATURE OF CLERK	
36. SIGNATURE OF DECEASED		37. SIGNATURE OF NEXT OF KIN		38. SIGNATURE OF CLERGYMAN		39. SIGNATURE OF BURIAL OFFICIAL		40. SIGNATURE OF FUNERAL HOME	
41. SIGNATURE OF CORONER		42. SIGNATURE OF JURY		43. SIGNATURE OF JUDGE		44. SIGNATURE OF SHERIFF		45. SIGNATURE OF CLERK	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF NEXT OF KIN		48. SIGNATURE OF CLERGYMAN		49. SIGNATURE OF BURIAL OFFICIAL		50. SIGNATURE OF FUNERAL HOME	
51. SIGNATURE OF CORONER		52. SIGNATURE OF JURY		53. SIGNATURE OF JUDGE		54. SIGNATURE OF SHERIFF		55. SIGNATURE OF CLERK	
56. SIGNATURE OF DECEASED		57. SIGNATURE OF NEXT OF KIN		58. SIGNATURE OF CLERGYMAN		59. SIGNATURE OF BURIAL OFFICIAL		60. SIGNATURE OF FUNERAL HOME	
61. SIGNATURE OF CORONER		62. SIGNATURE OF JURY		63. SIGNATURE OF JUDGE		64. SIGNATURE OF SHERIFF		65. SIGNATURE OF CLERK	
66. SIGNATURE OF DECEASED		67. SIGNATURE OF NEXT OF KIN		68. SIGNATURE OF CLERGYMAN		69. SIGNATURE OF BURIAL OFFICIAL		70. SIGNATURE OF FUNERAL HOME	
71. SIGNATURE OF CORONER		72. SIGNATURE OF JURY		73. SIGNATURE OF JUDGE		74. SIGNATURE OF SHERIFF		75. SIGNATURE OF CLERK	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF NEXT OF KIN		78. SIGNATURE OF CLERGYMAN		79. SIGNATURE OF BURIAL OFFICIAL		80. SIGNATURE OF FUNERAL HOME	
81. SIGNATURE OF CORONER		82. SIGNATURE OF JURY		83. SIGNATURE OF JUDGE		84. SIGNATURE OF SHERIFF		85. SIGNATURE OF CLERK	
86. SIGNATURE OF DECEASED		87. SIGNATURE OF NEXT OF KIN		88. SIGNATURE OF CLERGYMAN		89. SIGNATURE OF BURIAL OFFICIAL		90. SIGNATURE OF FUNERAL HOME	
91. SIGNATURE OF CORONER		92. SIGNATURE OF JURY		93. SIGNATURE OF JUDGE		94. SIGNATURE OF SHERIFF		95. SIGNATURE OF CLERK	
96. SIGNATURE OF DECEASED		97. SIGNATURE OF NEXT OF KIN		98. SIGNATURE OF CLERGYMAN		99. SIGNATURE OF BURIAL OFFICIAL		100. SIGNATURE OF FUNERAL HOME	

BUREAU V. 2

SEP 9 1957

RECEIVED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9458

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hurlock</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x 2 Hurlock - Rural</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Poplar Street</b>				d. STREET ADDRESS <b>East New Market Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Monroe</b> Last <b>Stanley</b>				4. DATE OF DEATH Month <b>September</b> Day <b>3</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 8, 1900</b>		9. AGE (in years last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>American Stores Cannery</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Stanley</b>				14. MOTHER'S MAIDEN NAME <b>Henrietta (maiden name unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>199-03-9297</b>		17. INFORMANT Address <b>Celia Stanley, Hurlock, Maryland, R.F.D.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>5 mon.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b></b> a. m. <b></b> p. m. <b></b> Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>John Mace Jr.</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 7, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>East New Market Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>East New Market, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>9/5/57</b>		24b. REGISTRAR'S SIGNATURE <b>John Mace Jr.</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MD. STATE DEPT. OF HEALTH—BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V.

SEP 9 1957

RECEIVED  
SEP 9 1957



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09460

Reg. Dist. No.

9459

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East New Market</u>	c. LENGTH OF STAY IN 1b <u>70 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East New Market</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Henrietta</u> Middle <u>Thompson</u> Last		4. DATE OF DEATH Month <u>September</u> Day <u>26</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/18/1872</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Hill</u>	
14. MOTHER'S MAIDEN NAME <u>Fannie Gray</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>	
16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Elizabeth Howard, East New Market, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c) <u>  </u> DUE TO (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>John Mace Jr.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John Mace Jr. M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>9/29/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/29/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>	22d. LOCATION (City, town, or county) (State) <u>East New Market, Md.</u>
24a. REC'D BY REGISTRAR DATE <u>9/29/57</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - BALTHAMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 9

OCT 7 1957

RECEIVED

*John M. M. M.*

*John M. M. M.*

*John M. M. M.*

9435

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Wingate Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Md. Hospital</u>				e. STREET ADDRESS <u>1 Wingate Md.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>M.</u> Last <u>Todd Jr.</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>29</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June</u>		9. AGE (In years last birthday) <u>79</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>29</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Waterman</u>		11. BIRTHPLACE (State or foreign country) <u>Wingate Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John M. Todd Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Sidney Powley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-16-8737</u>		17. INFORMANT <u>Leonard Todd</u> Address <u>324 S. Woodward Dr. Essex Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rt. Cerebral Hemorrhage</u> DUE TO <u>Hypertensive Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Stroke</u> DUE TO (c) <u>Stroke</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a. m. <u>39</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>104 Locust</u>	
20f. (City or town) <u>Cambridge Md.</u>				20g. (County) <u>Essex</u>			
20h. (State) <u>Md.</u>				20i. (Country) <u>USA</u>			
21. I certify that I attended the deceased from <u>7/24</u> , 19 <u>57</u> , to <u>9/29</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/29</u> , 19 <u>57</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.							22. DATE THEREOF <u>10/1/57</u>
ACTUAL SIGNATURE <u>W. H. Hanks</u> M.D. <u>104 Locust</u> ADDRESS (Street, city or town, state) <u>Cambridge Md.</u> DATE SIGNED <u>9/30/57</u>							23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>
PHYSICIAN'S NAME (Type) <u>W. H. Hanks</u>							24. REC'D BY REGISTRAR <u>John Mace Jr.</u>
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>							22b. DATE THEREOF <u>10/1/57</u>
22c. NAME OF CEMETERY OR CREMATORY <u>Pritchett Family Cem.</u>							22d. LOCATION (City, town, or county) (State) <u>Wingate Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>							24b. REGISTRAR'S SIGNATURE <u>John Mace Jr.</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

OCT 7 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09462

9436

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Dorchester Co.</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u> c. LENGTH OF STAY IN 1b <u>On Arrival</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Md. Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge Md.</u> d. STREET ADDRESS <u>1 408 Hughlett St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Ovelia</u> Middle <u>Pritchett</u> Last <u>Todd</u>				<b>4. DATE OF DEATH</b> Month <u>Sept.</u> Day <u>16.</u> Year <u>19 57</u>									
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Jan. 6, 1888</u>		<b>9. AGE</b> (In years last birthday) <u>69</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>        </u> Days <u>        </u>		<b>IF UNDER 24 HRS.</b> Hours <u>        </u> Min. <u>        </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Crochern Md.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>John L. Pritchett</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Frances Murphy</u>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>None</u>				<b>17. INFORMANT</b> <u>Alice Todd</u>				<b>Address</b> <u>Cambridge Md.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <u>Coronary occlusion</u>  <b>DUE TO</b>          Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.          (b) _____  <b>DUE TO</b>          (c) _____       </div> <b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>10 min.</u>													
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>													
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>        </u> a. m. <u>        </u> p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>													
<b>ACTUAL SIGNATURE</b> <u>John Mace Jr.</u>						<b>DATE SIGNED</b> <u>9/18/57</u>							
<b>EXAMINER'S NAME (Type)</b> <u>John Mace Jr. M.D.</u>						<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>9/18/57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Dorchester Mem. Park</u>				<b>22d. LOCATION (City, town, or county)</b> (State) <u>Cambridge Md.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>LeCompte Funeral Service</u>						<b>ADDRESS</b> <u>Cambridge Md.</u>							
<b>24a. REC'D BY REGISTRAR</b> <u>9/18/57</u>						<b>24b. REGISTRAR'S SIGNATURE</b> <u>John Mace Jr.</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MISSISSIPPI STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
SEP 24 1957  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09463

Reg. Dist. No.

9437

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.5em;">Dorchester</span> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <span style="font-size: 1.5em;">Maryland</span> b. COUNTY <span style="font-size: 1.5em;">Dorchester</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.5em;">Cambridge</span>			c. LENGTH OF STAY IN 1b <span style="font-size: 1.5em;">Few Days</span>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.5em;">X1</span>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <span style="font-size: 1.5em;">Cambridge-Md Hospital</span>				d. STREET ADDRESS <span style="font-size: 1.5em;">Linus Road</span>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) First <span style="font-size: 1.5em;">Daniel</span> Middle <span style="font-size: 1.5em;">Henry</span> Last <span style="font-size: 1.5em;">Travers</span>				<b>4. DATE OF DEATH</b> Month <span style="font-size: 1.5em;">Sept.</span> Day <span style="font-size: 1.5em;">30</span> Year <span style="font-size: 1.5em;">19 57</span>			
<b>5. SEX</b> <span style="font-size: 1.5em;">Male</span>		<b>6. COLOR OR RACE</b> <span style="font-size: 1.5em;">Negro</span>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <span style="font-size: 1.5em;">March 26, 1880</span>	
<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.5em;">77</span> yrs.		<b>IF UNDER 1 YEAR</b> Months      Days      Hours      Min.		<b>IF UNDER 24 HRS.</b> Months      Days      Hours      Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.5em;">Laborer</span>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.5em;">Lumbering</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.5em;">Dorchester Co., Md</span>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.5em;">USA</span>			
<b>13. FATHER'S NAME</b> <span style="font-size: 1.5em;">Major Travers</span>				<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.5em;">Elizabeth Travers</span>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <span style="font-size: 1.5em;">No</span> (If yes, give war or dates of service) <span style="font-size: 1.5em;">-----</span>				<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.5em;">213-12-5138</span>		<b>17. INFORMANT</b> Address <span style="font-size: 1.5em;">Alice Molock, Linas Road, Md.</span>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="font-size: 1.5em;">Coronary occlusion</span> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <span style="font-size: 1.5em;">420.1</span> DUE TO (c) <span style="font-size: 1.5em;">Few Min.</span>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <span style="font-size: 1.5em;">19. WAS AUTOPSY PERFORMED?</span> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <span style="font-size: 1.5em;">19</span>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <span style="font-size: 1.5em;">John Mace Jr.</span>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DATE SIGNED</b> <span style="font-size: 1.5em;">10/2/57</span>	
<b>EXAMINER'S NAME (Type)</b> <span style="font-size: 1.5em;">John Mace Jr.</span>		<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.5em;">Burial</span>		<b>22b. DATE THEREOF</b> <span style="font-size: 1.5em;">10/4/1957</span>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.5em;">Linus Road Cemetery</span>	
<b>22d. LOCATION (City, town, or county)</b> <span style="font-size: 1.5em;">Linus Road, Md.</span>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <span style="font-size: 1.5em;">[Signature]</span>		<b>ADDRESS</b> <span style="font-size: 1.5em;">Cambridge, Md.</span>		<b>24a. REC'D BY REGISTRAR</b> <span style="font-size: 1.5em;">10/3/57</span>	
<b>24b. REGISTRAR'S SIGNATURE</b> <span style="font-size: 1.5em;">John Mace Jr.</span>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

OCT 7 1957

RECEIVED

9438

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge Md.</u>			
c. LENGTH OF STAY IN 1b <u>4 Days</u>				d. STREET ADDRESS <u>208 Glenburn Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Md. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Gilbert</u> First <u>M.</u> Middle <u>Tull</u> Last			4. DATE OF DEATH Month <u>Sept.</u> Day <u>19</u> Year <u>19 57</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 27, 1893</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Dealer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Auto Sales</u>		11. BIRTHPLACE (State or foreign country) <u>Reides Grove Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>George M. Tull</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-05-9685</u>		17. INFORMANT <u>Mrs. Gilbert M. Tull</u> Address <u>208 Glenburn Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Toxic dermatitis, acute</u> <u>245x</u> DUE TO (b) <u>Drug sensitivity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Sept 15</u> , 19 <u>57</u> , to <u>Sept 19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept 19</u> , 19 <u>57</u> , and that death occurred at <u>5 PM</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city or town, state) <u>Cambridge Md</u> DATE SIGNED <u>Sept 20, 57</u>			
PHYSICIAN'S NAME (Type) <u>  </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/21/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>East New Market Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>East New Market Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				ADDRESS <u>Cambridge Md.</u>		24a. REC'D BY REGISTRAR DATE <u>9/20/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>John Thomas Jr.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09465

9460

## CERTIFICATE OF DEATH

Reg. Dist. No.

116

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>1yr. 6mo. 16das</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharptown</u> <u>22x2.2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS -		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Maggie</u> Middle <u>Jane</u> Last <u>Twiford</u>				4. DATE OF DEATH Month <u>September</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-6-81</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>William T. English</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Hasting</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -		17. INFORMANT <u>RECORDS - Eastern Shore State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> DUE TO (c) <u>Hypertension</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>1 1/2 hours</u> <u>1 1/2 hours</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-25</u> , 19 <u>57</u> , to <u>9-25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9-25</u> , 19 <u>57</u> , and that death occurred at <u>7:45 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Harry J Crawford</u>				M.D. <u>E.S.S. Hospital, Cambridge, Md.</u> <u>9-25-57</u>			
PHYSICIAN'S NAME (Type) <u>Dr. H. J. Crawford</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-27-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Firemans</u>		22d. LOCATION (City, town, or county) (State) <u>Sharptown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Gamm</u>				ADDRESS <u>Sharptown, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. John Macey</u>	

RECEIVED

9461

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>16 Eastern Shore State Hospital</u>				d. STREET ADDRESS <u>213 Byrn ST</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>George Washington Wallace</u>				4. DATE OF DEATH <u>Sept 15 1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 2 1872</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Golden Hill, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Slaighton Wallace</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Slacum</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Hospital Records Cambridge Md</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Arteriosclerosis</u> <u>450.0</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Unk</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>Dec 15</u> , 1955, to <u>Sept 15</u> , 1957, that I last saw the deceased alive on <u>Sept 15</u> , 1957, and that death occurred at <u>1:40 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>State Hosp Cambridge Md</u> DATE SIGNED <u>9-15-57</u>							
ACTUAL SIGNATURE <u>Thomas J. Dredge</u> M.D.				DATE SIGNED <u>9-15-57</u>			
PHYSICIAN'S NAME (Type) <u>Thomas J. Dredge</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/17/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Madison Church</u>		22d. LOCATION (City, town, or county) (State) <u>Madison, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>				ADDRESS <u>Cambridge Md</u>		24a. REC'D BY REGISTRAR <u>John Mason Jr.</u>	
				DATE <u>10/22/57</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 1

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 1912		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Carpenter		7. MARITAL STATUS Married		8. EDUCATION High School		9. RELIGION Roman Catholic		10. RACE White	
11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural		13. DATE OF DEATH 1957		14. PLACE OF DEATH Home		15. SIGNATURE OF PHYSICIAN J. H. Harris	
16. SIGNATURE OF REGISTRAR J. H. Harris		17. SIGNATURE OF WITNESS J. H. Harris		18. SIGNATURE OF DECEASED J. H. Harris		19. SIGNATURE OF NEXT OF KIN J. H. Harris		20. SIGNATURE OF BURIAL OFFICIAL J. H. Harris	

BUREAU V. S.

OCT 23 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09466

Reg. Dist. No.

9462

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Dorchester</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u>			c. LENGTH OF STAY IN 1b <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hurlock</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>---</u>				d. STREET ADDRESS <u>Academy Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>CORA</u> Middle <u>***</u> Last <u>WOOLEN</u>				<b>4. DATE OF DEATH</b> Month <u>September</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-14-72</u>		9. AGE (In years last birthday) <u>85</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Woolen</u>				14. MOTHER'S MAIDEN NAME <u>Mary Frances Harper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Ira Woolen, Hurlock, Maryland</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to strangulation</u> <u>974x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased tied rope around neck and plunged downstairs</u>					
20c. TIME OF INJURY Hour <u>10:00</u> a. m. <u>pm.</u> Month, Day, Year <u>9-24- 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) <u>Hurlock</u> (County) <u>Dorchester</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Eldridge H. Wolff</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9-25-57</u>	
EXAMINER'S NAME (Type) <u>Eldridge H. Wolff, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-26-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington</u>		22d. LOCATION (City, town, or county) <u>Hurlock</u> (State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John S. McElroyby, E. H. Market</u>				ADDRESS <u>---</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 27 57</u>	
24b. REGISTRAR'S SIGNATURE <u>---</u>				24c. REGISTRAR'S NAME <u>---</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



